WORKERS' COMPENSATION BOARD

S20085

State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) S4-Suspension, Claimant Death

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.
The Claim Administrator has suspended indemnity benefits for the reasons reflected in the Suspension Section of this document.

Employee Name JOHN DOE Scenario 4-5

WCB Case Number (JCN) G0055555 **Date of Injury** 08/01/2012

Claim Administrator Claim Number TW0892356 **Maintenance Type Code Date** 08/30/2012

Claim Type I - Indemnity **WCB Received Date** 02/01/2013

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx6789 **Insurer ID** W123456

CLAIM ADMINISTRATOR INFORMATION

Name ALL AMERICAN INSURANCE COMPANY **FEIN** xxxxx6789

Claim Representative Name MARY CLARK **Postal Code** 12110

Business Phone Number 5187855000 **Fax Number** 5187855001

E-mail Address mclark@allamerican.com **Claim Admin ID** W123456

Late Reason

EMPLOYEE INFORMATION

First Name JOHN **Middle Name/Initial**

Last Name DOE Scenario 4-5 **Suffix**

Date of Birth 11/01/1977

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx6745

CLAIM INFORMATION

Date Employer Had Knowledge of Date of Disability 08/01/2012

Work Days Scheduled (S-Scheduled N-Non Scheduled)

S	M	T	W	T	F	S
N	S	S	S	S	S	N

Calculated Wage $1,050.00

Calculated Weekly Compensation Amount $700.00

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

Employment Status 1 - Full Time

Work Week Type S - Standard Work Week

Wage Period 01 - Weekly

SAMPLE

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Type of Loss 01 - Trauma **Date of Maximum Medical Improvement**

Death Result of Injury No **Date of Death** 08/29/2012

WORK STATUS

Initial Date Disability Began 08/02/2012

Initial Return to Work Date

Return To Work Same Employer

SUSPENSION

Suspension Effective Date 08/29/2012

Suspension Reason

Clt subsequently passed away 8/29/12 as a result of injury. Will be filing new claim.

BENEFITS

Reduced Benefit Amount

Estimated Gross Weekly Amt.

Benefits

Benefit Types
050 - Temporary Total

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
050	08/02/2012	08/29/2012	4		08/02/2012	$700.00	08/02/2012	$700.00	08/29/2012	$2,800.00

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount

PAYMENTS

Award/Order Date

SAMPLE

Recoveries

Recovery Type	Amount

Reduced Earnings

Week Number	Actual Reduced Earnings

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx8765 **Insured FEIN** xxxxx8765

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

SAMPLE